Dingell Amendment to H.R. 3962

- It lets the Secretary work with states that have alternative programs to state high risk pools as a part of the new temporary insurance program.
- It provides that if the premiums of a retiree increase by an excessive amount, as determined by the Secretary, on or before the bill's introduction date (October 29, 2009), then such retiree is eligible for the high-risk pool.
- It prohibits undocumented individuals from accessing assistance from the national high risk pool program with requirements for verification of citizenship or lawful presence.
- It establishes a process for the review and public disclosure of health insurance premium increases and justifications by the Secretary of Health and Human Services and states. It permits the Commissioner to take into consideration excessive and unjustified premium increases in making decisions regarding which insurance companies will be permitted into the exchange and how quickly to open the exchange to employers for the purchase of insurance for their employees and provides funding for states to for this process.
- It clarifies that the consumer collaborative provided for in the early access health grants is a nonprofit business collaborative.
- It provides that the new Commissioner may permit a qualified health benefits plan to provide coverage through a qualified direct primary care medical home plan.
- The FTC may investigate insurance companies that are registered as not-for-profit companies.
- It clarifies that nothing in the Act overrides a state law governing medical malpractice cases.
- It repeals the McCarran-Ferguson Act insurance antitrust exemption with respect to health insurers and medical malpractice insurance.
- It imposes performance assessment and accountability measures on the Health Choices Administration.
- It provides that those women receiving Medicaid assistance only for family planning services would be eligible for the Health Insurance Exchange.
- It ensures that the interstate insurance compacts do not override state laws governing rate review and fraud and that compacting states determine which of the compacting state's laws serve as primary for the insurance company.
- It extends the Maryland all-payor cost containment waiver to the public option.
- It delays by 2 years a provision of the bill that eliminates the deductibility of expenses that relate to retiree prescription drug benefits that are subsidized by the federal government.
- It replaces a provision in the bill that delays the application of worldwide allocation of interest with a provision that deletes the allocation rule.
- It closes a biofuel tax credit loophole.
- It changes from January 1, 2010, to April 1, 2010, the effective date for Skilled Nursing Facilities classification changes.
- It permits approval for expansion of certain hospitals that have a high percentage of Medicaid admissions.

- States may agree to reimburse long-term care facilities for costs incurred in conducting background checks.
- It imposes quality indicators for Alzheimer's care.
- It imposes a 90-day wait period for new durable medical equipment suppliers to be paid if the Secretary believes there is a risk for fraud.
- It requires that the Medicare fraud and abuse phone number be prominently displayed on Explanation of Benefits forms.
- It provides for Medicaid coverage of Compact of Free Association migrants.
- It includes a sense of Congress regarding Medicaid coverage of community-based attendant services and supports.
- It includes technical appropriations provisions.
- It provides that the medical malpractice demonstration projects do not preempt or modify state laws on attorneys' fee limits or damage caps.
- It provides for a new program on mental health and substance abuse screening, intervention, referral, and recovery services.
- It codifies the Office of Minority Health.
- It requires HHS to study and eliminate any duplicative programs.
- It provides for diabetes screening collaboration and outreach.